Medical electives: a chance for international health

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The global shortage of health workers

Despite globalization, global health inequity has increased. The World Health Report 2006 stated, 'A shortage of human resources has replaced financial issues as the most serious obstacle to implementing national HIV treatment plans'.[1] New initiatives must tackle diverse system problems such as 'brain drain', training and recruitment. The Crisp report recognized the need for global health partnerships to tackle current and future international health (IH) challenges.[2]

Tapping into the enthusiasm of medical students

Although idealistic aims attract students to medical school, ideals fade throughout their training.[3] The role of IH in medical education has grown since the early 1990s,[4,5] with the elective giving most doctors their first exposure to IH. Positive experiences can shape future career choices and practices.[6] As the *Lancet* noted, 'No other part of the course transforms students so rapidly and profoundly, and both they and their teachers argue strongly that the overseas elective should find a secure place in any new medical curriculum'.[7]

Box 1
Reasons why medical students go on elective to developing countries

- To experience a different healthcare setting/practice
- To experience a different culture/country/demography
- To experience a different set of diseases and treatments
- To gain experience at procedures not possible at home
- To holiday

Consensus guidelines are lacking regarding the role of elective students,[8,9] despite numerous guidelines in home institutions.[10] Some believe that an elective student's role is to observe and not to 'practise medicine on the poor'. Others believe that some help is better than none, and that students have knowledge and skills which they should use. Still others believe that students should do what they would be expected to do in their home country within the boundaries of safety.[8]

There are currently 33 UK medical schools and approximately 6000 medical students per year. In 2004, 40% of UK students spent their 6–12-week elective period in developing countries (Box 1).[9] Many links exist between medical schools in developed countries and hospitals/clinics in poorer countries, but coordination is currently lacking. Medical students themselves have taken the lead, via comprehensive websites such as 'The Elective Network' (www.electives.net). The current model centres on Western students/doctors, neglecting the needs of the developing country health systems.

Medical students as doctors

Electives occur towards the end of training and so students have the knowledge required to start practising as a doctor. Several UK medical schools have final examinations before the elective. Therefore, elective students may not be provisionally registered with the General Medical Council, but they have the knowledge needed to practise medicine.

If even 10% of the current UK student pool acted as health workers in organized programmes, this would represent 600 students to supplement local healthcare personnel annually. In certain settings, such numbers of trained personnel could have a huge impact. There is sufficient overlap

between the timing of elective of medical schools, such that a programme could be staffed all year round. A four-week preparatory module prior to the elective had positive outcomes.[9] Similar modules could ensure adequate preparation before proposed programmes.

There are many areas where senior medical students would be competent to act as health workers. In under-served areas, secondary prevention services for cardiovascular disease in terms of guideline-based blood pressure and diabetes monitoring, improving access to drugs and sex education are examples. Programmes emphasizing primary care, health promotion and prevention would be most suitable.

Answering criticisms

The anticipated criticism is that medical students are not doctors and cannot act as health workers from an ethical or medicolegal perspective. At present, Western medical schools take most of the responsibility, but some of that responsibility is shared by the host university/medical institution. The student is expected to follow the same guidelines that they would in their home countries. The proposed scheme uses the existing infrastructure, and so liability will remain unchanged. Properly prepared students, acting within the limits of their knowledge and competency, will not compromise their or their patients' safety.

Lack of continuity of any scheme based on medical students may be a concern as placements last 6–12 weeks. If programmes are developed so that there is overlap between cohorts of students of at least one week, then handover is possible. Additionally, local health workers will be involved in supervision of the programme and ensure that services are provided throughout the year. As pressures on time increase in postgraduate training, clinicians wanting to engage in IH may have to concentrate on shorter placements abroad.

To most students, electives are an opportunity to leave the rigid curriculum. However, there is no need for coercion; a substantial proportion of UK medical students already choose to spend their elective at their own cost in rural areas of developing countries. The above arguments would hopefully convince enough students to participate.

Critics will question the utility of a few extra medical students in countries with complex systemic problems. However, in the above example, if 600 UK students are involved in coordinated, local schemes, then the use of current human resources could be optimized. If the scheme is successful in the UK, it can be extended to tap into the pool of international elective students, leading to much greater potential numbers of health workers.

Conclusions

There is very limited literature regarding the medical student elective, even though it is part of medical training throughout the world, and electives have often been viewed as periods of medical tourism.[9] The many links which often exist in isolation between Western medical schools and hospitals/clinics or schools in developing countries can be better organized to improve health outcomes. The proposed scheme uses the existing elective infrastructure in the UK, but requires greater coordination and a change in the view of the elective within medical schools. Such revolutions in medical education culture have occurred in the last 20 years with communication skills and ethics/humanities integrated into clinical curricula, and there is no reason that a similar paradigm shift cannot occur with regard to electives. This proposal warrants further discussion and development with relevant stakeholders, including medical schools, government, professional organizations, medicolegal organizations and healthcare providers in developing countries. Doctors, particularly students, can be catalysts for social change, and such a scheme has potentially far-reaching consequences on health and development.

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